



Benefits Collaborative Policy Statement

WOMEN'S HEALTH SERVICES

Women's health services are preventative and problem-specific health care services for women. The services listed below are not inclusive of all services available to women on Medicaid, but comprise a list of the most common health care services for women.

Eligible Providers

- Physician
- Osteopath
- Nurse Practitioner
- Certified Nurse-Midwife
- Physician Assistant
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist
- Family Planning Clinic
- Public Health Agency
- Non-Physician Practitioner Group

Eligible Places of Service

- Office
- Clinic
- Home
- School
- Federally Qualified Health Center
- Rural Health Center
- Hospital
- Ambulatory Surgery Center
- Family Planning Clinic
- Public Health Agency

Eligible Clients

All female Medicaid clients are eligible for women's health services.

Covered Services

Office Visits:

- A comprehensive, annual gynecological exam will be covered once per year, no fewer than ten months apart.
- As needed for follow-up visits and problem-specific care.

Cervical Cancer Screening and Follow-Up Services:

- Routine cervical cancer screenings are covered, as well as follow-up screenings and procedures based on screening results and client risk factors.

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- Providers should follow generally accepted clinical guidelines with respect to initiation and frequency of cervical cancer screenings and management of abnormal cervical cancer screening results.
- Generally accepted clinical guidelines include initiation of cervical cancer screenings within three years of the onset of sexual activity or at age 21, whichever occurs first, and then every one to two years until age 30. After age 30, frequency can be reduced to every three years if the client's three prior screenings have been normal.
- Human papillomavirus (HPV) testing and typing are covered in accordance with generally accepted clinical guidelines for indication and frequency.
- For abnormal cervical cancer screening results, covered services include increased frequency of cervical cancer screenings, HPV testing and typing in accordance with generally accepted clinical guidelines, and diagnostic services such as colposcopy, and ablative and excisional procedures for treatment such as loop electroexcisional procedures (LEEPs).

Sexually Transmitted Disease/Infection Testing, Risk Counseling and Treatment:

- Routine screening in accordance with generally accepted practice guidelines as well as periodic testing and counseling based on client risk factors and symptoms are covered benefits.
- Testing can include, but is not limited to, gonorrhea, Chlamydia, HIV/AIDS, herpes, syphilis, trichomoniasis, HPV, and hepatitis.
- Common treatments for sexually transmitted diseases/infections are covered
 - * If a generic form of the prescribed pharmaceutical or supply exists, then the generic alternative must be dispensed unless prior authorization is obtained for dispensing the brand-name pharmaceutical or supply. (See Pharmacy Policy for details on how to obtain prior authorization for pharmaceuticals.)

Human Papillomavirus (HPV) Vaccination:

- The HPV vaccine series is a covered benefit for clients age 9 through 26.*
 - * See Billing Guidelines section for specific billing requirements for vaccines.

Mammography:

- Providers should follow generally accepted clinical guidelines with respect to initiation and frequency of mammography services based on client age, risk factors, and symptoms
- Generally accepted clinical guidelines include initiation of screening mammograms at age 40 and every one to two years thereafter. Earlier initiation of screening and increased frequency of mammography is covered only for clients who are at high risk for or have a history of breast disease.
- Breast ultrasound and breast MRI services are covered if additional imaging studies are required or on the basis of certain high risk factors.
- Image-guided needle biopsy is covered for the diagnosis and treatment of breast disease.

Mastectomy:

- Mastectomy, lumpectomy, and breast excision are covered benefits for the treatment of a breast disease.

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- Bilateral mastectomy is a covered benefit when there is a known breast disease in either breast. Prophylactic bilateral mastectomy with no known disease present and/or no personal history of breast disease is not a covered benefit.
- A maximum of two mastectomy brassieres may be reimbursed per year and do not require prior authorization.

Breast Reconstruction Procedures:

- Breast reconstruction is covered for clients with a history of a breast disease diagnosis and surgical procedure (e.g. mastectomy) within the prior five years.
- Breast reconstruction procedures that may be covered with appropriate prior authorization include, but are not limited to, mastopexy; insertion of breast prostheses; the use of tissue expanders or reconstruction with a transverse rectus abdominis myocutaneous (TRAM) flap, deep inferior epigastric perforator (DIEP) flap, or similar procedure; nipple and areolar reconstruction and tattooing; and reduction mammoplasty on the unaffected breast for symmetry.
- All breast reconstruction procedures must be prior authorized and meet medical criteria.

Breast Reduction Procedures:

- Breast reduction procedures for macromastia are covered when medically necessary and when all medical criteria are met, including the documented failure of alternative treatments for macromastia.
- All breast reduction procedures must be prior authorized and meet medical criteria.

Hysterectomy:

- Hysterectomy is a covered benefit when medically necessary. (Hysterectomy for the sole purpose of sterilization is not a covered benefit.)
- Clients must give consent and sign a consent statement prior to the procedure indicating their understanding that a hysterectomy will render them incapable of reproducing
- Written consent from the client is not required when a client is already sterile at the time of the procedure or if the procedure is required because of a life-threatening emergency in which the provider determines that prior consent from the client is not possible
- There are no age limitations regarding hysterectomy
- Consult Billing Guidelines for specific requirements regarding claim submission and client consent statement

Special Programs

Breast and Cervical Cancer Program (BCCP):

BCCP is a special type of Medicaid eligibility for women who have been diagnosed with breast or cervical cancer at certain screening clinics in Colorado called Women's Wellness Connection sites (WWC) and are not otherwise eligible for Medicaid. BCCP also covers treatment for diagnosed precancerous breast and cervical conditions that may lead to cancer if not treated.

Women who meet the following criteria are eligible for BCCP:

- Have been diagnosed through a WWC site;
- Are between 40 and 64 years old;

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- Have an income less than 250% of the Federal Poverty Level;
- Have not had a mammogram or Pap smear test in the last year;
- Do not have health insurance or it does not cover breast or cervical cancer treatment;
- Are not currently enrolled in Medicaid and are not eligible for Medicare; and
- Are U.S. citizens or have been legal permanent residents for at least five years.

Clients enrolled in BCCP are eligible for the same benefits as those enrolled in regular Medicaid. Clients remain eligible for BCCP until they are no longer in active treatment for breast or cervical cancer or precancerous condition; until they turn 65; or until they obtain other insurance or become eligible for Medicare.

Non-Covered Services

- BRCA genetic mutation testing for breast and ovarian cancer susceptibility
- Prophylactic bilateral mastectomy with no known breast disease present or personal history of breast disease
- Hysterectomy for the sole purpose of sterilization or if more than one purpose for the hysterectomy exists but the procedure would not have been performed but for the purpose of sterilization

Prior Authorization Requirements

- All breast reconstruction and reduction procedures require prior authorization*
* Consult the Provider Billing Manuals for detailed prior authorization request instructions

Billing Guidelines

* Consult the Provider Billing Manuals for detailed billing instructions

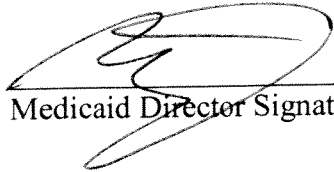
- HPV Vaccination: For clients age 9 through 20, the HPV vaccine must be obtained through the Vaccines for Children Program or the Infant Immunization Program. Providers not participating in the Vaccines for Children Program or the Infant Immunization Program will not be reimbursed for providing the HPV vaccine to clients age 9 through 20. For clients age 21 through 26, providers do not have to obtain the vaccine through a special program and will be reimbursed on a per-injection basis.
- Hysterectomy: Hysterectomy claims must be submitted on paper. A copy of the client's consent statement or the provider's certification that the client was already sterile or required an emergency hysterectomy must be attached to all claims submitted for hysterectomy services. A suggested form on which to report the required information is attached. Providers may copy this form, as needed, for attachment to claims. Providers may substitute any form that includes the required information. The submitted form must be signed and dated by the provider performing the hysterectomy. Claims will be denied if a copy of the written consent statement or provider's statement is not attached.

Legal References

Cervical cancer screening guidelines – U.S. Preventive Services Task Force
www.ahrq.gov/clinic/uspstfix.htm

Mammography guidelines – U.S. Preventive Services Task Force
www.ahrq.gov/clinic/uspstfix.htm

42 CFR 441.255- Hysterectomy regulations



Medicaid Director Signature

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Date